INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Wednesday, 15 October 2025

Minutes of the meeting of the Inner North East London Joint Health Overview and Scrutiny Committee held at Committee Room 2 - 2nd Floor West Wing, Guildhall on Wednesday, 15 October 2025 at 7.00 pm

Present

Members:
Common Councillor, David Sales (Chairman)
Councillor Susan Masters (Vice-Chair)
Councillor Gulam Kibria Choudhury
Councillor Ben Hayhurst
Councillor Ahmodul Kabir
Councillor Danny Keeling
Councillor Ben Lucas
Councillor Sam O'Connell
Councillor Richard Sweden
Councillor Jennifer Whilby

Officers:

Zina Etheridge	-	Chief Executive, NEL ICB
Dr Paul Gillouly	-	Chief Clinical and Quality Commissioning Officer, NEL ICB
Ralph Coulbeck	-	Chief Strategy Officer, NEL ICB
Lorraine Sunduza	-	Chief Executive East London NHS Foundation Trust
Henry Black	-	Chief Finance Officer, NEL ICB
Dr Janakan Crofton	-	GP/ Medical Director ARMP
Sindhu Balakrishnan	-	Chief Operating Officer ARMP
Polly Dunn	-	Assistant Town Clerk, City of London Corporation
Scott Myers	-	Town Clerk's Department, City of London Corporation
Isaac Thomas	-	Town Clerk's Department, City of London Corporation

1. **ELECTION OF CHAIR**
RESOLVED – That, in accordance with the Committee's Terms of Reference, Common Councillor David Sales was declared to be Chairman for the ensuing year.

The Chairman welcomed Members to Guildhall, as well as those joining the meeting remotely, and proceeded to thank the Committee for allowing the City of London Corporation to host the upcoming Inner North East London Overview and Scrutiny Committee meetings for the next two years.

2. **ELECTION OF VICE CHAIR**
RESOLVED – That, in accordance with the Committee's Terms of Reference, Councillor Susan Masters (Newham) being the only Member indicating their willingness to serve was declared to be Vice-Chairman for the ensuing year.

3. **APOLOGIES FOR ABSENCE AND SUBSTITUTE MEMBERS**

Apologies for absence were received from Councillor Anna Lynch and Councillor Daniel Morgan-Thomas. Councillor's Ahmodul Kabir and Sam O'Connell joined the meeting remotely.

4. **MEMBER'S DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

There were none.

5. **MINUTES**

The minutes of the meeting held on 13 May 2025 were agreed as a correct record.

6. **PUBLIC PARTICIPATION**

Stephanie Davies-Arai addressed the Committee in relation to the Cass Review and its implications for schools and children's services. Ms Davies-Arai raised concerns regarding social transition in schools and the progression to irreversible medical treatments. She also questioned the wider implications of the Cass Review for professionals working with children.

Lynne Troughton, Hackney Councillor, spoke to the Committee in her capacity as a Hackney resident on matters relating to the Cass Review. Ms Troughton expressed concern that health authorities were not implementing the Secretary of State for Health's commitment to adopt the Cass Review recommendations following the Supreme Court judgment on the definition of sex. She noted that new guidance had been issued by the Department for Education and suggested there was no justification for delaying implementation of the Cass Review recommendations by health authorities. Ms Troughton raised concerns regarding gender affirmation practices within general practice, suggested the establishment of a working party to develop a strategy for children currently on waiting lists, and proposed that a statement of intent be issued acknowledging government policy on this matter. Ms Troughton also raised concerns regarding private clinics operating without sufficient oversight.

9. **LGBTQ+ HEALTH SERVICES**

The Chairman informed the Committee that item 9 would be taken ahead of item 7.

The Committee received a report of Dr Paul Gillouly, Chief Clinical and Quality Commissioning Officer, NHS North East London, concerning LGBTQ+ Health Services. Dr Gillouly introduced the item and provided an overview of the current provision of gender identity services for children and young people. He explained that services had previously been delivered nationally through the Tavistock and Portman NHS Foundation Trust, and that concerns regarding clinical pathways had led NHS England to commission Professor Hilary Cass to undertake an independent review. The final Cass Review, published on 10 April 2024, made 32 recommendations relating to care provision, NHS pathways and future research.

Dr Gillouly reported that following the closure of the Tavistock service in April 2024, two new services had opened in Manchester and London, with plans for up to eight regional centres nationally. Gender identity services for children and young people were now commissioned nationally. The waiting list stood at approximately 6,100 patients, of whom three were registered within the North East London ICB. Members were also informed that legislation had been introduced restricting the prescription of puberty blockers for children, with prescription permitted only within approved research settings for children with gender dysphoria.

In response to a question regarding patient safety, Dr Gillouly stated that he was not personally aware of any deaths by suicide among those on the waiting list following the introduction of the restrictions on puberty blockers, but undertook to confirm this and circulate further information to Members after the meeting. He explained that it was difficult to quantify the number of children requiring additional mental health support following the restrictions, as co-morbidity was common and many children referred to gender services were also known to CAMHS, often presenting with other mental health or neurodiversity-related needs.

The Committee asked whether the closure of the Tavistock service had contributed to increased waiting times. Dr Gillouly advised that the waiting list had been closed prior to the service's closure, which had resulted in further increases.

A Member queried whether the activities and discourse of far-right activists had impacted NHS staff or the treatment of transgender patients. Dr Gillouly reaffirmed the NHS's commitment to inclusive, respectful and compassionate care for all patients.

Members queried the relatively low number of North East London patients on the waiting list and asked whether unmet local need was being assessed. Dr Gillouly advised that unmet need would be identified through CAMHS, which continued to provide support to children while they remained on the national waiting list. He further indicated that additional data on children presenting with gender-related issues outside of the specialist service could be provided following the meeting.

The Committee questioned why the waiting list remained high given the reported assessment timeframe. Dr Gillouly explained that the list was managed and triaged nationally, with patients prioritised according to clinical need and subsequently transferred to individual hospital waiting lists.

Referring to the public participation element at Item 6, a Member asked whether the ICB had any remit to direct schools, GPs or other clinicians in relation to children assuming particular gender identities, and whether this was addressed in the Cass Review. Dr Gillouly confirmed that the NHS had no responsibility for the education system and that this did not fall within the remit of the ICB, nor was it a recommendation of the Cass Review.

Members asked how the effectiveness of inclusion initiatives such as Pride in Practice was being reviewed. Dr Gillouly reported that a range of practices were engaging with the programme, noting that approximately 75% of GP practices in Tower Hamlets had participated. Pride in Practice recognised inclusive healthcare through a bronze, silver and gold award framework, and positive feedback had been received from staff across clinical and non-clinical roles. He acknowledged that knowledge gaps remained and that repeat engagement would be necessary. In response to questions about increasing uptake, Dr Gillouly stated that funding was available through the training hub to support wider participation across North East London, subject to practice engagement.

RESOLVED: That Members: -

- Noted the report.

7. HEALTH UPDATE

The Committee received the report of Zina Etheridge, Chief Executive NEL ICB, covering specific provider updates, organisational change, the NHS 10 Year Plan and an update on planning and priorities to manage winter pressures. Ms Etheridge advised the Committee that this would be her final INEL JHOSC meeting prior to her departure and informed Members that Ralph Coulbeck had been appointed as Interim Chief Executive while recruitment to a substantive post was undertaken. Mr Coulbeck, currently the Chief Strategy Officer at the NEL ICB, briefly introduced himself and outlined his background within the NHS.

Ms Etheridge provided an update on organisational change within the ICB, noting that while national announcements regarding ICB restructuring were made earlier in the year, progress had stalled due to the absence of a national decision on funding for redundancies. As a result, wider reorganisation and staff consultation had not yet commenced. Members were informed that the ICB had nevertheless completed a restructure of its senior leadership team to reflect a shift toward a strategic commissioning model. It was also confirmed that Dame Marie Gabriel had been formally appointed as Chair of the ICB.

The Committee received an overview of the strategy refresh and planning process for 2025–2030. Draft versions of the refreshed strategy and initial commissioning plans had been shared with providers and partners across the system. The strategy was informed by extensive public and user engagement and placed the Good Care Framework and the Outcomes and Equity Framework at its centre, aligned with the three shifts outlined in the NHS 10-Year Plan. Emphasis had been placed on the development of a Neighbourhood Commissioning Framework and forthcoming Neighbourhood Health Plans, which would require sign-off by local Health and Wellbeing Boards.

Members were also advised of changes to NHS England regional structures, including the forthcoming merger of NHS England functions into the Department of Health and Social Care. London regions would continue to hold

responsibility for provider regulation, performance management, and regional strategy.

In response to questions regarding health inequalities, officers outlined how a health inequalities and equity lens had been embedded across all commissioning activity over the past three years. It was emphasised that future commissioning would increasingly focus on health inequities, recognising that different communities required different approaches to achieve equitable outcomes. An example was provided of targeted maternity work at Newham Hospital, where data-led interventions with a specific ethnic community had resulted in improved birth outcomes.

Members expressed concern about the balance between strategy development and delivery and requested clearer examples of measurable improvements for residents. Officers acknowledged the importance of demonstrating tangible impact and agreed that data-driven, community-specific interventions were key to future progress.

The Committee discussed the future of place-based working, with Members raising concerns about variation between boroughs, the sustainability of the current ICB model, and the erosion of the original expectation that the majority of funding would be spent at place level. Ms Etheridge stated that there was no current intention to abolish ICBs and that place and neighbourhood working remained central to the system's approach. She confirmed that Health and Wellbeing Boards were expected to play an important governance role, particularly in relation to neighbourhood health plans. Work was also underway to define core community service offers across North East London to reduce unwarranted variation while allowing local flexibility.

The Committee noted that this was the first meeting since the June Old Bailey judgement relating to the tragic death of a patient in 2015. A Member raised concerns regarding the court findings, including issues around falsified records and the quality of risk assessments, and referred to repeated concerns raised by coroners in relation to record keeping at both the East London NHS Foundation Trust and North East London NHS Foundation Trust. Members expressed concern about the resulting impact on public confidence and sought assurance regarding leadership oversight and actions taken to ensure such issues were not continuing. Lorraine Sunduza, Chief Executive East London NHS Foundation Trust, clarified that the jury had found the Trust not guilty of corporate manslaughter, but guilty of a health and safety breach. Furthermore, a member of staff had been found not guilty of gross negligent manslaughter but guilty of a health and safety breach. Sentencing for both the Trust and the individual was expected later in the year, and national work was underway to consider the wider implications of the case.

Ms Sunduza outlined the Trust's response, noting that a quality improvement programme on observation practices and record-keeping had been established and emphasised that, alongside individual accountability, the Trust was addressing systemic issues through audits, spot checks, training, and staff support. Members were advised that reliability and timeliness of observations

had improved. A Member sought further assurance that this work was being tested at a corporate level, including whether regular audit or spot-check findings could be published. Ms Sunduza confirmed that checks and audits were ongoing and that the Trust continued to review both individual practice and systemic factors to strengthen patient safety and transparency.

The Committee also considered issues raised in response to the Mental Health Action Group open letter, including concerns regarding the availability of longer-term talking therapies. Ms Sunduza explained that services operated a stepped care model, where interventions were tailored to individual need. While many talking therapy interventions were time-limited, service users could be stepped up to more intensive secondary care psychological services where clinically appropriate, or stepped down to lower-level ongoing support through primary care. Initial triage informed the pathway but did not preclude access to longer-term or more intensive support where required.

Members asked for further information regarding peer support workers, noting the lack of statistical detail in the report. Ms Sunduza confirmed that peer support workers were embedded across all directorates, but that work was underway, in partnership with North East London NHS Foundation Trust, to standardise and professionalise the role. This included aligning job descriptions, banding, training, supervision, and career progression. Responding to a query regarding Mental Health Support Teams in schools, Ms Sunduza confirmed that plans to establish three additional teams in City and Hackney, Havering, and Waltham Forest in January 2026 remained on track.

Further clarification was provided on the meaning of ‘step up’ and ‘step down’ within the stepped care model. Step-up care involved referral to community mental health teams and access to more intensive multidisciplinary support, including psychiatry and psychology. Step-down care involved lower-intensity ongoing support, often through general practice, where specialist input was no longer required.

RESOLVED: That Members: -

- Noted the report.

8. **FINANCE REVIEW**

The Committee received a report of Henry Black, Chief Finance Officer NEL ICB, providing a review of key financial headlines.

The Committee discussed the cash flow implications of the loss of deficit support funding, particularly for North East London Foundation Trust and Barts Health NHS Trust, which were experiencing working capital pressures and had required emergency cash support from NHS England to meet financial commitments.

In response to questions regarding the future financial framework, Mr Black explained that the ICB would continue to be responsible for commissioning all services, including acute care. Provider organisations would be accountable for

delivering services within agreed contract values, with direct regulatory oversight where providers failed to operate within their financial limits. The ICB's role would increasingly focus on commissioning, contract setting, and population-level financial balance rather than direct operational performance management.

RESOLVED: That Members: -

- Noted the report.

10. **IMPROVING GP ACCESS IN NORTH EAST LONDON**

The Committee received a report of the Deputy Director of Primary Care Commissioning concerning efforts to improve access to GP services across North East London. The Committee was updated on the ICB's focus on modernising access models, rather than solely increasing appointment numbers, and on work undertaken over recent years to bring general practice access into line with twenty-first century expectations.

In response to questions, Dr Crofton, GP/ Medical Director ARMP, acknowledged that there was variation in access and maturity of primary care across boroughs. He explained that the ICB now used primary care dashboards to identify pressures and provide earlier, targeted support, including quality improvement programmes, bespoke practice visits, and system-wide webinars to share best practice. Members were advised that recent contractual changes required practices to offer online access throughout core hours, and that early evidence suggested this was achievable, although safety and equity considerations remained important.

Members raised concerns about digital exclusion, the absence of a single blueprint for online access, and the risk of impersonal centralised access models replacing continuity with GP practices. Officers confirmed that while national and local quality improvement support was available, access models needed to be tailored to local demographics. Digital inclusion remained a priority, and Members were advised that further work could be undertaken to develop a clearer ICB-wide framework.

Discussion also covered the role of neighbourhood health centres and the impact of large-scale housing developments on primary care capacity. Officers confirmed that the ICB worked with local authorities and partners through estate and infrastructure forums to plan health provision for growing populations, though funding mechanisms did not always fully reflect rapid population growth.

RESOLVED: That Members: -

- Noted the report.

11. **THE SCRUTINY REPORT**

The Committee received a report of the Town Clerk.

Members expressed thanks to officers for their hard work and the public for their engagement.

RESOLVED: That Members: -

- Noted the report and appendices.

The meeting ended at 21.02pm

Chairman

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